

Patient Health Record

Name _____ Date of Birth ____/____/____ SSN _____ - ____ - _____

Medical History

Are you currently under the care of a physician? Y ____ N ____

Name of physician _____ Phone _____

Address _____

Are you currently taking any medication? Y ____ N ____

If yes, what, and for what purpose? _____

Are you allergic to: ____ penicillin ____ local anesthetics ____ latex ____ other

Have you had x-rays of any kind in the last 5 years? Y ____ N ____

Do you: ____ smoke ____ chew tobacco ____ use alcohol ____ use drugs for recreation

Have you ever been tested / treated for: ____ hepatitis ____ HIV/AIDS ____ Alcohol or drug abuse

Have you ever been told to take medication (antibiotics) before dental treatment? Y ____ N ____

Are you currently taking a daily aspirin or blood thinner? Y ____ N ____

Women: Are you pregnant? _____ Nursing? _____ Taking birth control pills? _____

Do you have or have you ever been informed of having:

	Y	N		Y	N		Y	N
Heart disease. . . .	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart defects.	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever . . .	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal blood pressure. . . .	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic valves or joints . . .	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases. . .	<input type="checkbox"/>	<input type="checkbox"/>

Is there any medical condition not listed here that we should be aware of? _____

Dental History

When was your last dental visit? _____ Were x-rays taken? Y ___ N ___

Have you ever had any serious problems with previous dental treatment? Y ___ N ___

Are you missing any teeth that you would be interested in replacing? Y ___ N ___

Have you ever had prolonged bleeding following extractions? Y ___ N ___

Have you ever been told that you have gum (periodontal) disease? Y ___ N ___

Do your gums bleed while brushing or flossing? Y ___ N ___

Are any of your teeth sensitive to: _____ hot _____ cold _____ sweets _____ chewing / pressure

Are you aware of any problems with your teeth or gums at this time? Y ___ N ___

Have you ever experienced any of the following:

- clenching or grinding your teeth? Y ___ N ___
- clicking sounds in your jaws? Y ___ N ___
- tired, painful or aching facial / jaw muscles? Y ___ N ___
- difficulty in opening, closing or chewing? Y ___ N ___
- frequent headaches, stiff neck or shoulder pain? Y ___ N ___

Have you ever been advised to wear a dental appliance for TMJ symptoms? Y ___ N ___

Cosmetic Evaluation

Advances in the dental field have made it possible to offer “Hollywood Smiles” with new, non-invasive techniques.

Are you pleased with your smile? Y ___ N ___

If you could change the appearance of your teeth, what would you change?

color _____ shape _____ size _____ position _____ other _____

Would you be interested in improving your smile with:

Teeth whitening ___ Invisalign (invisible braces) ___ Lumineers (no-drill veneers) ___

X

Signature of patient or parent if minor

Date